The California Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, CA 95814
(916) 324-4695 FAX: (916) 324-4878

May 23, 2008

NOTICE OF PROPOSED RULEMAKING
ER-1-08

TITLE 10. INVESTMENT. CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.8. MANAGED RISK MEDICAL INSURANCE BOARD
HEALTHY FAMILIES PROGRAM
AMEND SECTIONS 2699.6500 (r); 2699.6803; 2699; and 6805

NATURE OF PROCEEDING

NOTICE IS HEREBY GIVEN that the Managed Risk Medical Insurance Board (MRMIB) is proposing to take the action described in the Informative Digest.

A public hearing regarding this proposal will be held on July 7, 2008 at 1:30 p.m., at 1000 G Street, 4th Floor, Suite 450, Front Conference Room, Sacramento, CA 95814.

Following the public hearing MRMIB may thereafter adopt the proposal substantially as described below or may modify the proposals if the modifications are sufficiently related to the original text. With the exception of technical or grammatical changes, the full text of any modified proposal will be available for 15 days prior to its adoption from the person designated in this Notice as contact person and will be mailed to those persons who submit written comments related to this proposal, or who provide oral testimony at the public hearing, or who have requested notification of any changes to the proposal.

Notice is also given that any interested person, or his or her authorized representative, may submit written comments relevant to the proposed regulatory action to the

Managed Risk Medical Insurance Board
Attn: JoAnne French
1000 G Street, Suite 450
Sacramento, CA 95814

Comments may also be submitted by facsimile (FAX) at (916) 327-6580 or by e-mail to jfrench@mrmib.ca.gov. Comments must be submitted prior to 5:00 p.m. on July 7, 2008.

AUTHORITY AND REFERENCE
Pursuant to the authority vested by Section 12693.21 and 12693.755, Insurance Code; and Reference Sections: 12693.02, 12693.03, 12693.045, 12693.06, 12693.065, 12693.08, 12693.09, 12693.10, 12693.70, 12693.105, 12693.11, 12693.12, 12693.13, 12693.14, 12693.16, 12693.17, 12693.21, 12693.37, 12693.755, and 12693.91, Insurance Code. Amendment of Sections 2699.201; 2699.205; 2699.207; 2699.209; and 2699.400.

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW
In 1997, the Federal Government established the State Children's Health Insurance Program (SCHIP), by adding Title XXI to the Social Security Act. Pursuant to AB 1126 (Chapter 623, Statutes of 1997), California established a SCHIP insurance program called Healthy Families Program (HFP). The program is administered by the Managed Risk Medical Insurance Board (MRMIB). HFP is targeted to serve children whose family income, although low, is too high to qualify for the Title XIX Medicaid Program, called Medi-Cal in California. The structure of HFP is set out in Insurance Code Sections 12693, et seq. and Chapter 5.8, Title 10 of the California Code of Regulations.

AB 1126, Chapter 623, Statues of 1997, contained provisions to ensure MRMIB provides each HFP applicant a choice of providers, including Traditional and Safety Net (T&SN) providers. The statute creating the CPP designation process provides: 1) stability for the T&SN providers who had historically provided services to children who would qualify for HFP when the program began; 2) continuity of care for newly enrolled HFP members; 3) inclusion of providers who share cultural and linguistic characteristics with the HFP population; and 4) incentive for plans to contract with a variety of providers to ensure subscribers' choice and access to services among providers. The statute provides MRMIB great discretion in determining which plan in each county had done the best job of including T&SN providers in its network and to designate that plan the Community Provider Plan (CPP) in any given county. (Insurance Code section 12693.42(d)). For plans with a CPP designation, MRMIB allows a discount per child on the monthly family contribution (premium). All plans are encouraged to compete for the CPP designation by expanding their T&SN networks. The regulations set forth the process of developing the T&SN lists and designating the CPP winner in each county.

In March 2008 MRMIB submitted proposed emergency regulations to the Office of Administrative Law (OAL). These regulations were approved effective March 26, 2008. The emergency regulations modified the time frames for the designation of the CPP provider. This proposed rulemaking includes those emergency regulations as well as other technical changes that MRMIB is proposing to modify the CPP process that were not submitted as proposed emergency regulations. These combined proposed regulations will be noticed to the public and a public hearing will be held.

There are no comparable provisions of federal law related to this proposal.

LOCAL MANDATE
This proposal does not impose a mandate on local agencies or school districts.

FISCAL IMPACT ESTIMATES
This proposal does not impose a mandate on local agencies or school districts for which reimbursement would be required pursuant to Part 7 (commencing with Section 17500 of Division 4 of the Government Code). This proposal does not impose other nondiscretionary cost or savings on local agencies. This proposal does not result in any cost or savings in federal funding to the state.

COSTS OR SAVINGS TO STATE AGENCIES
There are no associated costs or savings to state agencies.

BUSINESS IMPACT/SMALL BUSINESS
MRMIB has made an initial determination that the proposed regulatory action would have no significant statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states. The proposal does not affect small businesses as defined by section 11342.610. The determination that the proposal would not affect small business is based upon the fact that the proposal makes technical procedural changes. The proposal has no impact at all on any entity that is not a state agency as defined in section 11000 of the California Government Code as the regulations only establish procedures.

ASSESSMENT REGARDING EFFECT ON JOBS/BUSINESSES
The MRMIB has determined that this regulatory proposal will not have any impact on the creation of jobs or new businesses or the elimination of jobs or existing businesses or the expansion of businesses in the State of California.

COST IMPACTS ON REPRESTATIVE PERSON OR BUSINESS
The MRMIB is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action.

EFFECT ON HOUSING COSTS
None

CONSIDERATION OF ALTERNATIVES
In accordance with section 11346.5(a)(13) of the Government Code, the Department must determine that no reasonable alternative considered or that has otherwise been identified and brought to the attention of the Department would be more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons than the proposed regulatory action.

CONTACT PERSONS
Inquires concerning the proposed adoption of this regulation and written comments may be directed to:

JoAnne French
Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, CA 95814
(916) 327-7978

or

Randi Turner
Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, CA 95814
(916) 327-8243

INITIAL STATEMENT OF REASONS
The MRMIB has prepared an initial statement of reasons for the proposed action and has available all the information upon which the proposal is based.

TEXT OF PROPOSAL
Copies of the exact language of the proposed regulations and of the initial statement of reasons, and all of the information upon which this proposal is based, may be obtained upon request from the Managed Risk Medical Insurance Board at 1000 G Street, Suite 450,Sacramento, CA 95814. These documents may also be viewed and downloaded from the MRMIB website at www.mrmib.ca.gov

AVAILABILITY AND LOCATION OF THE FINAL STATEMENT OF REASONS AND RULEMAKING FILE
All the information upon which the proposed regulations are based is contained in the rulemaking file which is available for public inspection by contacting the person named above.

You may obtain a copy of the final statement of reasons once it has been prepared by making a written request to the contact person named above.

WEBSITE ACCESS
Materials regarding this proposal can be found at www.mrmib.ca.gov

STATE OF CALIFIRONIA
MANAGED RISK MEDICAL INSURANCE BOARD
1000 G STREET, SUITE 450
SACRAMENTO, CA 95814

TITLE 10. CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.8 MANAGED RISK MEDICAL INSURANCE BOARD
HEALTHY FAMILIES PROGRAM
ARTICLE 4. RISK CATEGORIES AND FAMILY CONTRIBUTIONS
AMEND SECTIONS 2699.6500(r); 2699.6803; 2699.6805

INITIAL STATEMENT OF REASONS
ER-1-08

INTRODUCTION

In 1997, the Federal Government established the State Children's Health Insurance Program (SCHIP), by adding Title XXI to the Social Security Act. Pursuant to AB 1126 (Chapter 623, Statutes of 1997), California established a SCHIP insurance program called Healthy Families Program (HFP). The program is administered by the Managed Risk Medical Insurance Board (MRMIB). HFP is targeted to serve children whose family income, although low, is too high to qualify for the Title XIX Medicaid Program, called Medi-Cal in California. The structure of HFP is set out in Insurance Code Section 12693, et seq. and Chapter 5.8, Title 10 of the California Code of Regulations.

AB 1126 contained provisions to ensure MRMIB provides each HFP applicant a choice of providers, including Traditional and Safety Net (T&SN) providers. The statute creating the CPP designation process provides: 1) stability for the T&SN providers who had historically provided services to children who would qualify for HFP when the program began; 2) continuity of care for newly enrolled HFP members; 3) inclusion of providers who share cultural and linguistic characteristics with the HFP population; and 4) incentive for plans to contract with a variety of providers to ensure subscribers' choice and access to services among providers. The statute provides MRMIB great discretion in determining which plan in each county had done the best job of including T&SN providers in its network and to designate that plan the Community Provider Plan (CPP) in any given county. (Insurance Code section 12693.42(d)). For plans with a CPP designation, MRMIB allows a discount per child on the monthly family contribution (premium). All plans are encouraged to compete for the CPP designation by expanding their T&SN networks. The regulations set forth the process of develop the T&SN lists and designating the CPP winner in each county.

In March 2008 MRMIB submitted to Office of Administrative Law (OAL), and OAL approved, emergency regulations modifying the time frames for the designation of the CPP provider. The effect of the emergency regulations is described below in connection with the specific subsection modified in these proposed regulations.

SPECIFIC PURPOSE OF EACH SECTION – GOVERNMENT CODE 11346.2(b)(1)

Proposed Amendments to Section 2699.6805

The purpose of the proposed regulations is to modify the CPP designation process in response to stakeholders input and a staff report analysis on potential changes to the process. The more specific purposes are to: (1) clarify the timeline for the preparation of the preliminary list of CHDP, clinic, and hospital T&SN providers, (2) specify the types of clinics and the amount of Medical services require for clinics to be placed on the clinic list, (3) exclude acute psychiatric hospitals, health facilities, and chemical dependency recovery hospitals from the hospital list, (4) clarify that health plans, as well as providers, to submit revisions to the T&SN lists during a 30-day period after the preliminary lists were prepared, (5) clarify the CHDP provider scoring method, and (6) modify the clinic weighting factor between the number of T&SN clinics located in a county and the number of services each of the T&SN clinics provided.

Rationale for the Necessity of the Changes

Subsection (a) is grammatical and necessary to clarify the meaning of the subsection.

Subsection (b) clarifies the date the Board is to make available the county-specific CHDP, clinic, and hospital T&SN provider lists.

Subsection (c)(1) clarifies the benefit year in which the data to develop the CHDP list will be pulled and clearly defines a child as being between the ages of 1 and 18. The section also clarifies how the percentage assigned to each CHDP provider is calculated.

Subsection (c)(2) clarifies the benefit year in which the data to develop the clinic list will be pulled and specifically lists the types of clinics to be included on the clinic list. The subsection also establishes that clinics must provide a minimum of fifteen (15) services to children with Medi-Cal coverage in order to be included on the clinic list and clarifies that each health clinic will have a percentage assigned to it.

The specific types of clinics are listed to ensure that only those clinics that provide primary care services are included on the clinic list. Establishing a minimum number of services provided by each clinic will ensure that the clinic list reflects clinic providers that serve more than one or two children per year and truly do fit the category of traditional and safety net provider.

Subsection (c)(3)(A) clarifies the benefit year in which the data to develop the hospital list will be pulled. The subsection clarifies that psychiatric and substance abuse hospitals are not to be included on the hospital list.

Psychiatric and substance abuse hospitals are not included on the hospital list because they provide a specialized service and the purpose of the CPP process is to focus on

providers that serve a broad array of low income people who historically have been uninsured.

Subsection (c)(3)(B) specifies the year in which the data to develop the hospital list will be pulled. The subsection corrects a grammatical error and clarifies that hospitals outside a given county that serve a Medi-Cal, county indigent, or charity child from that county are to be included on the hospital list. The subsection clarifies that psychiatric and substance abuse hospitals are not to be included on the hospital list for the reasons stated immediately above.

Subsection (d) was formerly subsection (g) and has been relocated to reflect the order in which the steps occur to compile the lists. Subsection (d) is necessary to explain the procedure for making revisions to the T&SN provider lists.

Subsection (d)(1) authorizes any participating health plan, as well as any CHDP provider to propose a revision to the CHDP list and clarifies that the CHDP provider must meet specified criteria.

Subsection (d)(2) authorizes any participating health plan, as well as any clinic to propose a revision to the clinic list, and clarifies that the clinic must meet specified criteria.

Subsection (d)(3) authorizes any participating health plan as well as any hospital to propose a revision to the hospital list and clarifies that the hospital must meet specified criteria.

Subsection (e) is added to establish the requirement that the Board produce a final list of CHDP, clinic, and hospital T&SN providers for each county after the thirty (30) day revision period.

After the revision period has ended, the Board needs to produce a final list. The plans then use the final list to indicate which of the providers on the list are contracted in the each plan's provider network.

Subsection (d) is renumbered to (f) to conform with the newly added paragraph (e) and clarifies the timeframe in which plans must submit specified information to the Board.

Subsection (f)(1) clarifies the reference to subsection (e).

Subsection (f)(2) clarifies the reference to subsection (e).

Subsection (f)(3) clarifies the reference to subsection (e).

Subsection (e) is renumbered (g) to conform with the newly added paragraph (e).

Subsection (g)(1) clarifies the method for calculating the percentage assigned to each CHDP provider.

Subsection (g)(2) establishes a new formula for calculating the clinic percentage.

The new formula recognizes that not all clinics are providing equal service and attaches a higher weight to clinics that serve a larger number of low income people while still recognizing the importance of small clinics in serving the target population.

Subsections (g)(2)(A) and (B) modify the scoring method used for determining the percentage assigned to each clinic.

The new formula recognizes that not all clinics are providing equal service and attaches a higher rate to clinics that serve a higher number of low income people while still recognizing the importance of small clinics in serving the target population.

Subsection (g)(3) clarifies how the hospital percentage is calculated.

Subsection (h) is simply renumbered from subsection (f). The text of the proposed subsection is unchanged from the regulations adopted on an emergency basis in March 2008, presently contained in subsection (f).

Subsection (g) is deleted because its provisions have been amended and renumbered as subsection (d).

OTHER REQUIRED SHOWINGS – GOVERNMENT CODE 11346.2(b)(2)-(4)

Studies, Reports, or Documents Relied Upon – Gov. Code 11346.2(b)(2)

MRMIB relied upon the following documents in developing these Regulations:

- The Community Provider Plan Designation Process *Discussion of Issues Stakeholders Raised*, MRMIB Staff presented at July 19, 2006 Board Meeting
- The Community Provider Plan Designation Process *Discussion of Stakeholders' Responses to Issue Paper Presented at the July 19, 2006 Meeting*, MRMIB Staff presented at September 20, 2006 Board Meeting.

Reasonable Alternatives Considered – Gov. Code 11346.2(b)(3)(A)

None.

Reasonable Alternatives Considered that Would Lessen the Impact on Small Businesses – Gov. Code 11346.2(b)(3)(B): None

Evidence Relied Upon to Support the Initial Determination that the Regulation Will Not Have a Significant Adverse Economic Impact on Business – Gov. Code 11346.2(b)(4): There is no adverse economic impact on business as these changes are technical only and do not impact business.

STATE OF CALIFORNIA
MANAGED RISK MEDICAL INSURANCE BOARD
1000 G STREET, SUITE 450
SACRAMENTO, CA 95814

TITLE 10. INVESTMENT. CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.8. MANAGED RISK MEDICAL INSURANCE BOARD
HEALTHY FAMILIES PROGRAM
AMEND SECTION 2699.6500 (r); 2699.6803; 2699;6805

ARTICLE 1. DEFINITIONS

Text proposed to be added is displayed in underlined type.
Text proposed to be deleted is displayed in ~~strikeout~~ type**.**

Section 2699.6500 is amended to read:

2699.6500. Definitions.

* * *

(r) "Family value package" means the combination of participating health, dental, and vision plans available to subscribers in each county offering the lowest price and each of the combinations offering a price within seven and one half percent (7.5%) of the average price of the lowest priced combination and the second lowest price combination of health, dental, and vision plans. The second lowest price combination is calculated by summing the second lowest price health plan, the second lowest price dental plan, and the second lowest price vision plan. If only one health, dental, or vision plan is available to subscribers in a county, the price of the one available plan shall be used in the calculations of the second lowest price combination. A health, dental, or vision plan with a service area which does not include zip codes in which at least eighty-five percent (85%) of the residents of the county reside or that has enrollment limits unrelated to network capacity shall not be considered the lowest or second lowest price plan, unless it is the only health, dental, or vision plan in the county. In addition, any combination of health, dental, and vision plans in which the health, dental, and vision plan are each available in at least one plan combination that is within seven and one half percent (7.5%) of the average price of the lowest and second lowest price combination of health, dental, and vision plans, is a family value package.

In all family value package calculations, the health plan rate to be used is the rate for subscriber children from one year old up to the age of nineteen. The dental and vision plan rates to be used are the rates for subscriber children. ~~The family value package determinations shall be made once each year by the Board, no later than the last day of March for the following benefit year, based on calculations using the prices of the plans that at the time of the calculations are expected to be available the following benefit year.~~ When the Board calculates the family value package, it shall base the calculation on the plan prices expected to be available for the anticipated health, dental and vision plan contract terms. Calculations will not be redone if plans are later dropped from or added to a county. However, if the Board at any time determines that the seven and one half percent (7.5%) level is insufficient to assure that adequate network capacity exists in a specified county so that all subscribers may be enrolled in a family value package, the Board may increase the percentage for that county to a percentage at which sufficient capacity is assured. Such increased percentage shall be in effect only for the benefit year in which the increase is made. The Board may determine, if requested as a part of a rural demonstration project for a special population, that a combination of health, dental, and vision plans in a county with a price higher than the family value package may still be deemed a family value package for applicants and subscribers that are members of the special population; in addition the Board may determine, if requested as part of a rural demonstration project for rural area residents, that a combination of health, dental, and vision plans in a county with a price higher than the family value package may still be deemed a family value package for subscribers that are residents of the rural area. The Board may determine that a combination of health, dental, and vision plans in a county that includes health and vision plans available in at least one family value package plan combination is deemed a family value package even if the dental plan is not in any other family value package plan combination, but only for applicants with subscribers who are enrolled prior to the beginning of the benefit year in that dental plan, and only if the Board determines it necessary in order to avoid requiring fifty percent (50%) of subscribers or one-thousand (1,000) subscribers in a county to change their dental plan.

* * * *[continued]*

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.02, 12693.03, 12693.045, 12693.06, 12693.065, 12693.08, 12693.09, 12693.10, 12693.70, 12693.105, 12693.11, 12693.12, 12693.13, 12693.14, 12693.16, 12693.17, 12693.755 and 12693.91, Insurance Code.

ARTICLE 4. RISK CATEGORIES AND FAMILY CONTRIBUTIONS
AMEND SECTIONS 2699.6805(f) and 2699.6803

Text

Text proposed to be added is displayed in underlined type.
Text proposed to be deleted is displayed in ~~strikeout~~ type**.**

Section 2699.6803 is amended to read:

2699.6803. Annual Health, Dental and Vision Benefit Plan Rates.

Health, dental and vision benefit plan rates shall be established for each contract term ~~rating period and the rating period for the program shall be a twelve (12) month period~~.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.21, Insurance Code.

Section 2699.6805 is amended to read:

2699.6805. Designation of Community Provider Plan

(a) For each benefit year, the Board will designate as the community provider plan in each county the participating health plan with a service area ~~which~~ that includes zip codes in which at least eighty-five percent (85%) of the residents of the county reside and that has the highest percentage of traditional and safety net providers pursuant to the calculation in subsection ~~(e)~~(g) below.

(b) By the ~~end~~ first day of November of ~~each year~~ the benefit year immediately preceding the benefit year described in subsection (a), the Board shall compile and make available a list for each county of all Child Health and Disability Prevention Program (CHDP), clinic and hospital traditional and safety net providers.

(c) The lists shall be compiled as follows:

(1) The CHDP list shall include all CHDP providers, except for clinical laboratories, that were on the Department of Health Care Services ~~(DHS)~~*(DHCS)* CHDP Master File as of October 1st of ~~that year~~ the benefit year immediately preceding the benefit year described in subsection (a) and ~~which~~ that provided a ~~State-Only Funded~~ State-only funded CHDP service as identified on the CHDP Paid Claims Tape to at least one (1) child aged one (1) through eighteen (18) in the state fiscal year that ended immediately prior to the most recently ended state fiscal year. For each listed provider, the list shall indicate the percentage of

county children that received State-only funded CHDP services from the ~~identified~~ listed provider. ~~The number of county children shall be calculated by summing the numbers of children that received State-only funded CHDP services from each listed provider.~~ The percentage shall be calculated by dividing the number of county children receiving State-only funded services from the listed provider by the total number of county children receiving State-only funded services from all listed providers in the county.

(2) The clinic list shall include all ~~community clinics, free clinics, rural health clinics, and county owned and operated clinics, located in the county,~~ Community Outpatient Hospital Based Clinics, Rural Health Clinics, Federally Qualified Health Centers, Free Clinics, Community Clinics, Clinics Exempt from Licensure, County Clinics Not With Hospital and County Hospital Outpatient Clinics, in the county, ~~which~~ that were so identified by the Medi-Cal program as of October 1st of ~~that year~~ the benefit year immediately preceding the benefit year described in subsection (a) and ~~which~~ were identified on the Medi-Cal Paid Claims Tape as having provided at least (15) services to children ~~at least one (1) child~~ aged one (1) through eighteen (18) in the state fiscal year that ended immediately prior to the most recently ended state fiscal year. ~~For each clinic, the~~ The list shall indicate a percentage for each clinic which shall be equal to one (1) divided by the number of listed clinics in the county.

(3) The hospital list shall ~~include~~ be compiled as follows:

(A) For a county that has, located in the county, at least one hospital which, ~~was~~ as of October 1st of ~~that year~~ the benefit year immediately preceding the benefit year described in subsection (a), was a hospital eligible for the inpatient disproportionate share hospital payment program as reported by the Department of Health *Care* Services (DHCS), a University teaching hospital, a Children's Hospital (as defined in Section 10727 of the Welfare and Institutions Code), or a county owned and operated general acute care hospital, the list shall include all hospitals of one of these types whether or not they are located in the county and which reported to the Office of Statewide Health Planning and Development (OSHPD) discharging at least one resident of the county who was a Medi-Cal, county indigent, or ~~and~~ charity care patient aged one (1) through eighteen (18) in the year for which OSHPD most recently released its annual compilation of Discharge Data. ~~For each hospital, the~~ The list shall indicate, for each hospital, the percentage of the Medi-Cal, county indigent, and charity care discharges ~~from all listed hospitals~~ of county residents aged one (1) through eighteen (18) ~~that were~~ from the ~~identified~~ listed hospital. The hospital list shall not include acute psychiatric hospitals (as defined in Section 1250(b) of the Health and Safety Code), psychiatric health facilities (as defined in Section 1250.2(a) of the Health and Safety

Code), or chemical dependency recovery hospitals (as defined in Section 1250.3(a) of the Health and Safety Code).

(B) For all other counties, the list shall include all hospitals located in the county and all hospitals located outside the county, which, as of October 1st of the benefit year immediately preceding the benefit year described in subsection (a), discharged at least one resident of the county who was a Medi-Cal, county indigent, or charity care patient aged one (1) through eighteen (18) in the year for which OSHPD most recently released its annual compilation of Discharge Data and which were ~~a hospital~~ hospitals eligible for the inpatient disproportionate share hospital payment program as reported by the ~~DHS~~ *DHCS*, a university teaching hospital, a children's hospital (as defined in Section 10727 of the Welfare and Institutions Code), or a county owned and operated general acute care hospital. ~~For each hospital the~~ The list shall indicate, for each hospital, the percentage of the Medi-Cal, county indigent, and charity care discharges ~~from all listed hospitals~~ of county residents aged one (1) through eighteen (18) ~~that were~~ from the ~~identified~~ listed hospital. The hospital list shall not include acute psychiatric hospitals (as defined in Section 1250(b) of the Health and Safety Code, psychiatric health facilities (as defined in Section 1250.2(a) of the Health and Safety Code), or chemical dependency recovery hospitals (as defined in Section 1250.3(a) of the Health and Safety Code).

(d) The lists of CHDP providers, clinics and hospitals described in subsection (c) shall be revised only under the following circumstances:

(1) Any CHDP provider not included on a county list pursuant to subsection (c)(1) or any participating health plan that asserts the CHDP provider met the specified criteria to be on that list and was excluded in error may, within thirty (30) calendar days after the list described in subsection (b) is released by the Board, provide written documentation to the Board demonstrating that the CHDP provider met the criteria described in subsection (c)(1). If the Executive Director of the Board finds that the CHDP provider met the specified criteria then the CHDP provider shall be added to the county list.

(2) Any clinic not included on a county list pursuant to subsection (c)(2) or any participating health plan that asserts the clinic met the specified criteria to be on that list and was excluded in error may, within thirty (30) calendar days after the list described in subsection (b) is released by the Board, provide written documentation to the Board demonstrating that the clinic met the criteria as described in

subsection (c)(2). If the Executive Director of the Board finds that the clinic met the specified criteria then the clinic shall be added to the county list.

(3) Any hospital not included on a county list pursuant to subsection (c)(3) or any participating health plan that asserts the hospital met the specified criteria to be on that list and was excluded in error may, within thirty (30) calendar days after the list described in subsection (b) is released by the Board, provide written documentation to the Board demonstrating that the hospital met the criteria described in subsection (c)(3). If the Executive Director of the Board finds that the hospital met the specified criteria then the hospital shall be added to the county list.

(e) The Board shall compile and make available a final list for each county of all Child Health and Disability Prevention (CHDP), clinic, and hospital traditional and safety net providers after the 30-day revision period described in subsection (d) has expired.

~~(d)~~(f) By January 15th of ~~each year,~~ the benefit year immediately preceding the benefit year described in subsection (a), each participating health plan shall submit the following to the Board for each county ~~the following~~:

(1) A list of the CHDP providers identified by the Board pursuant to subsection ~~(c)(1)~~(e) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(2) A list of the clinics identified by the Board pursuant to subsection ~~(c)(2)~~(e) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(3) A list of the hospitals identified by the Board pursuant to subsection ~~(c)(3)~~(e) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

~~(e)~~(g) The percentage of traditional and safety net providers in the provider network of each participating health plan will be calculated by summing the CHDP percentage, the clinic percentage, and the hospital percentage.

(1) The CHDP percentage is calculated by summing the number of CHDP services provided to all children aged one (1) through eighteen (18) by listed CHDP providers within the county that were ~~percentages assigned to all CHDP providers in the county~~ identified by the plan pursuant to ~~(d)~~(f)(1), and dividing

this sum by the number of services provided by all listed CHDP providers in the county and multiplying that number by 0.35.

~~(2) The clinic percentage is calculated by summing the percentages assigned to all clinics in the county identified by the plan pursuant to (d)(2), and multiplying that number by 0.45.~~

(2) The clinic percentage is calculated by:

(A) Adding the percentages assigned to each listed clinic in the county pursuant to subsection (c)(2) that was identified by the plan pursuant to subsection (f)(2), and multiplying that percentage by 0.225; and adding the number produced by the calculation made in subsection (e)(2)(B) below.

(B) Dividing the number of services provided by each listed clinic in the county that was identified by the plan pursuant to subsection (f)(2) by the number of services provided by all listed clinics in the county pursuant to subsection (c)(2), and multiplying that percentage by 0.225.

(3) The hospital percentage is calculated by summing the percentages described in subsection (c)(3) assigned to all hospitals in the county identified by the plan pursuant to (d)(3), and multiplying that number by 0.2.

~~(f)~~(h) The Board shall ~~announce~~ designate a ~~the designation of the~~ community provider plan for each county ~~by March 31st of each year~~ for the benefit year ~~beginning on the next July 1st.~~ described in subsection (a). Notwithstanding subsection (h) of section 2600.6500, the designation shall take effect on the day the open enrollment transfers described in section 2699.6621 take effect, and the previous designation shall remain in effect until that time. Prior to designation, each plan's relationships with traditional and safety net providers may be verified by the Board.

~~(g) The lists of CHDP providers in (c)(1), clinics in (c)(2) and hospitals in (c)(3) shall only be revised under the following circumstances:~~

~~(1) Any CHDP provider not included on a county list pursuant to(c)(1) that believes it met the specified criteria to be on that list and was excluded in error, may within thirty (30) calendar days after the list is released by the Board, notify the Board that it so believes and provide written documentation demonstrating that it met the listed criteria. If the Executive Director of the Board finds that the CHDP provider did meet the specified criteria it shall be added to the county list.~~

~~(2) Any clinic not included on a county list pursuant to (c)(2) that believes it met the specified criteria to be on that list and was excluded in error, may within thirty (30) calendar days after the list is released by the Board, notify the Board that it so believes and provide written documentation demonstrating that it met the listed criteria. If the Executive Director of the Board finds that the clinic did meet the specified criteria it shall be added to the county list.~~

~~(3) Any hospital not included on a county list pursuant to (c)(3) that believes it met the specified criteria to be on that list and was excluded in error, may within thirty (30) calendar days after the list is released by the Board, notify the Board that it so believes and provide written documentation demonstrating that it met the listed criteria. If the Executive Director of the Board finds that the hospital did meet the specified criteria it shall be added to the county list.~~

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21 and 12693.37, Insurance Code.